

MDR Tracking Number: M5-04-3959-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 01-20-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, ultrasound-spinal canal, x-ray exam, electrical stimulation, joint mobilization, manual traction, aquatic therapy, therapeutic activities, medical conference w/physician, analyze clinical data, neuromuscular stimulator and electrodes-pair were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 01-20-03 through 07-18-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 23rd day of September 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

September 10, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Typo corrected in "Disputed Services"

Re: Medical Dispute Resolution
MDR #: M5-04-3958-01

TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

- TWCC-60, Table of Disputed Services, EOB's
- Information provided by Requestor:
 - letter of medical necessity (08/13/04),
 - requests for reconsideration (02/10, 02/19, 05/14, 07/1, 07/25, 09/09, 09/18, 10/23),
 - S.O.A.P. notes (1/20/03 – 7/18/03),
 - NCV 04/25/03,
 - FCE 05/27/03,
 - lumbar MRI's 03/15/ & 04/05/00
- Information provided by Respondent:
 - peer review reports (02/10, 02/17, 03/17, 04/12, 04/14, 05/12, 05/20/2003),
 - H&P 7/8/03.
- Information provided by Pain Management Specialist:
 - H&P 5/14/03.
- Information provided by Orthopedic Surgeon:
 - consultation 7/16/04.

Clinical History:

The claimant was working when he was involved in a work-related event on _____. He presented to the office of a chiropractor on/about 04/05/00 and was initiated into a trial of chiropractic therapeutics. MR imaging of the lumbar spine performed on 04/05/00 revealed that the claimant had a sizable posterior central herniation/extruded disc migrating through the torn annulus at L5/S1.

Diagnostics that included NCV of the lower quarter performed on 04/25/03 revealed that the claimant has evidence of bilateral lumbosacral radiculopathy. Peer review performed by Dr. H, D.C. from 02/10/03 through 05/20/03 revealed that the provider has unreasonable goals set for the claimant and that there are no qualitative/quantitative events for continued therapeutic progression. Evaluation on 05/14/03 revealed that the claimant has a 5-6 mm disc herniation and that selective transforaminal epidural steroid injection series are appropriate and medically necessary.

Functional capacity evaluation (FCE) was performed on 05/27/03 and revealed that the claimant was operating within sedentary/light (PDL), had decreased AROM over the lumbar spine, was aerobically de-conditioned, and had weakness of major muscle groups in the lumbar/abdominal regions; the claimant was deemed to be a candidate for pain management applications. The claimant presented to the offices of an orthopedist on 07/16/04 and was advised of the necessity of implementing surgical applications that included lumbar laminectomy/discectomy.

Disputed Services:

Office visits, ultrasound-spinal canal, x-ray exam, electrical stimulation, joint mobilization, manual traction, aquatic therapy, therapeutic activities, medical conference w/physician, analyze clinical data neuromuscular stimulator and electrodes-**pair**, during the period of 01/20/03 through 07/18/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

The rationale of the provider to continue to implement passive applications in the management of this claimant's condition approximately four years from the date of injury is not medically appropriate and highly atypical among chiropractic specialists. There are no medical records submitted that establishes efficacy for the provider's course of management in a qualitative/quantitative manner.

In the 05/27/03 FCE, the provider clearly states that progression to chronic pain management is appropriate, yet he continues to utilize interdisciplinary therapeutics in the management of this claimant. The worker is a clear surgical candidate, and should have been progressed toward invasive surgical applications in the 6-8 months following the date of injury.

In the medical record, the provider has stated that he wanted to hold off surgery at all costs. This comment outlines the provider's bias towards necessary invasive applications that are vital in the management of the claimant's pain generators. The

provider's implemented course of interdisciplinary, passive therapeutic applications has been utterly ineffective in the management of this claimant's pain generators.

The aforementioned information has been taken from the following guidelines of clinical practice and/or peer reviewed references.

- *Unremitting Low Back Pain. North American Spine Society Phase III. Clinical Guidelines for Multidisciplinary Spine Care Specialists.* North American Spine Society. 2000. 96 p.
- Official Disability Guidelines, 9th Edition. *Intervertebral Disc Disorder (3-digit ICD-9 722).*
- *Overview of Implementation of Outcome Assessment Case Management In The Clinical Practice.* Washington State Chiropractic Association; 2001, 54p.
- Trino, J. et al. *Differences in Treatment History With Manipulation For Acute, Subacute, Chronic, and Recurrent Spine Pain.* J Manipulative Physiol Ther. 1992 Jan;15(1):24-30.
- Trionovich, S. J. et al. *Structural Rehabilitation Of The Spine And Posture: Rationale For Treatment Beyond Resolution Of Symptoms.* J Manipulative Physiol Ther. 1999 Jan;21(1):375-50.

Sincerely,